Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

HEALTHTRUST
PO BOX 89008
HOUSTON TX 77289

DWC Claim #: 09124391
Injured Employee: GLENDA M SCOTT
Date of Injury: 09/01/08
Employer Name: CATO CORP
Insurance Carrier #: YLLC75694

Respondent Name:
HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number:
M4-12-0866-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see the attached correspondence wherein HealthTrust has attempted to get the insurance carrier to render payment on the remaining open dates of service on this patient. HealthTrust received preauthorization by requesting an IRO to review the file. The IRO ruled in favor of HealthTrust and granted the 10 requested sessions. HealthTrust further requested 10 additional sessions and received preauthorization. 19 of the 20 dates of service have been paid for."

Amount in Dispute: $3,120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201339, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2011 January 14, 2011	CPT Code 97799-CP	$3,120.00	$1,600.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided January 13, 2011 and January 14, 2011.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 8, 2011 and March 11, 2011

- W9 – Unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medically unreasonable and/or unnecessary and documented srvc does not meet fee guideline contained w/I appli AMA CPT/HCPCS guide.

Issues

1. Did the requestor submit documentation to support the disputed dates of service were overturned by the Independent Review Organization in accordance with 28 Texas Administrative Code §133.308?
2. Is the requestor entitled to reimbursement?

Findings

The health care provider requested a review by and Independent Review Organization for preauthorization of the chronic pain management program. Upon the independent review, the previous adverse determination was overturned stating that "This patient has met the ODG guidelines for the requested services. There is sufficient documentation to clinically justify the requested chronic pain management program… Therefore, it is determined that the chronic pain management program 5x2, 10 sessions 97799 is medically necessary to treat this patient's condition." The requestor has submitted documentation to support that the respondent failed to reimburse the requestor for two

dates of service that were in the time frame of the IRO determination. Therefore, payment is recommended in accordance with Texas Administrative Code §134.204(h)(1)(B) ($125 x 8 = $1,000 x 80% = $800.00 x 2).

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,600.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $1,600.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 9, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.